

KNOWLEDGE, BARRIERS AND FACTORS AFFECTING THE USE OF FAMILY PLANNING METHODS AMONG COUPLES ASSESSING CARE IN AKWA IBOM STATE, NIGERIA

Akaninyene Mark¹

Affiliation: ¹Department of Public Health, Nigeria Police Medical Service State Headquarters
Uyo, Akwa Ibom State Nigeria

Correspondence to:

Email: akaninyeneakpan07@gmail.com

Citation: Akaninyene Mark (2024) Knowledge, barriers and factors affecting the use of family planning methods among couples assessing care in Akwa Ibom State, Nigeria. *Frontline Professionals Journal*, 1(1), 141 – 160.

ABSTRACT

Background: Assessing couples' knowledge, barriers and factors affecting the use of family planning methods is crucial for understanding their reproductive health needs. Family planning is a critical aspect of reproductive health, allowing individuals to make informed decisions about their fertility and reproductive well-being. Married couples represent a key demographic for family planning education and services, making them a key demographic for family planning education and services. Family planning is essential for reducing maternal and infant mortality: By spacing out pregnancies, women can reduce their risk of maternal mortality and ensure better health outcomes for their children. Family planning enhances educational and career opportunities. Family planning allows young women to pursue their educational and career goals without the burden of unintended pregnancies. It also supports economic empowerment by enabling individuals to plan their resources effectively: Family planning enables individuals to plan their families and resources more effectively, contributing to economic stability and growth. Spacing pregnancies helps ensure better care for younger children. This study aims to assess knowledge, barriers and factors affecting the use of family planning methods among couples attending antenatal services in Akwa Ibom State, Nigeria.

Methodology: A hospital-based descriptive cross-sectional study design using a systematic sampling method to select 323 participants in Uyo LGA, Akwa Ibom State. Data were collated,

analysed and presented using descriptive statistics with tables and frequencies. The majority 126(39%) of the respondents are within 34-41 years. The majority (96.3%) of the men know about family planning methods for men. The majority of 258(80%) know the barrier method (male condoms). Most 181(56%) of the respondents have used family planning methods before. The factors that affect accessing family planning services for males is mostly stigmatization (57.6%). Accessibility, cost and poor interest are a few of the barriers to assessing family planning methods

Conclusion: Understanding the factors, and barriers that affect family planning methods among couples attending antenatal services in Akwa Ibom State, Nigeria, is essential for developing effective reproductive health programs and services. By assessing couple's knowledge and identifying the barriers to family planning, healthcare providers and policymakers can work together to promote reproductive health and well-being among young adults in the region. It is therefore recommended reproductive health program designers incorporate these findings into reproductive health programs to help address barriers and factors affecting the use of family planning to improve the health outcomes among couples.

Keywords: Knowledge, Barriers, Factors Affecting, Family Planning Method among couples

INTRODUCTION

Family planning is a critical component of reproductive health, enabling individuals to make informed decisions about their fertility and well-being (World Health Organization, 2020). Married couples, being young adults, are at a stage where they have full liberty by marriage to engage in sexual activities, making them a key demographic for family planning education and services (Ezeh *et al.*, 2018). In Nigeria, where the population growth rate is high and access to reproductive health services is limited, family planning is essential for reducing maternal and infant mortality, enhancing educational and career opportunities, and supporting economic empowerment (National Population Commission, 2017). Research has shown that knowledge and awareness of family planning methods are crucial factors in their adoption (Adekanle *et al.*, 2017). However, studies have also highlighted the influence of cultural and social norms, access to services, peer influence, and socioeconomic status on the use of family planning methods among young adults (Bongaarts, 2017; Sedgh *et al.*, 2016). In Akwa Ibom State, Nigeria, where traditional values and social expectations may discourage or encourage family planning methods, understanding the barriers and factors that affect their use is essential for developing effective reproductive health programs and services (Udoh *et al.*, 2019). Looking at the statistic, the global population is expected to reach 8.6 billion by 2030. Many developing countries are already dealing

with the consequences of a large population. Unchecked population growth, in low-resource settings, presents diverse challenges to all and sundry. As a result, many countries put in place a variety of population policies to lower the high fertility rate. A proven strategy for fertility regulation is the effective use of contraceptives/ family planning methods. Contraceptive use benefits individuals, families, and society at large. It promotes national and global socioeconomic development, and improves women's reproductive health. It reduces the number of unintended pregnancies, and unsafe abortions and lowers maternal mortality. Conscious efforts are ongoing to encourage women of reproductive age to use contraception not forgetting the involvement of men in family planning services. Research supports a rise in the number of women aged 15–49 using contraceptives globally. For instance, there was a nine-point rise in the global contraceptive prevalence rate (CPR) from 55% in 1990 to 64% in 2015. A further increase from 663 to 851 million women aged 15–49 who used contraceptives was recorded between 2000 and 2020. Many developing countries with high fertility rates appear to miss out on this global uptick because of the low use of modern birth control measures. For example, sub-Saharan Africa (SSA) has the lowest modern contraceptive prevalence rate (mCPR) and accounts for 21% of the global total. Similar to SSA, the CPR is low in Nigeria, and efforts to improve it have largely been unsuccessful. In 2012, the Nigerian government, alongside some foreign donors, set a mCPR target of 27% by 2020. To meet this goal, there were initiatives to increase the availability of family planning services at all levels of healthcare. The target was also aimed at increasing media campaigns to persuade women to seek and accept free access to modern contraception. Despite these efforts, Nigeria's CPR among married women in 2018 was 17% for any method and 12% for mCPR. Nigeria's rising population, socioeconomic status, poor health indices, and maternal mortality indicators may be attributed in part to the country's inability to improve on its low mCPR. As a result, 48% of sexually active women and 19% of married women aged 15–49 who would otherwise like to avoid pregnancy have an unmet need for modern contraception/ family planning. In contrast to the low CPR, previous studies in Nigeria found high contraceptive knowledge among childbearing women aged 15–49. The low use of contraception in Nigeria can be attributed to individual, family, and community factors. Culture, religion, myths and misconceptions, the number of living children, employment status, lack of a partner's support, and other factors all undermine effective contraceptive use. As a result, the low mCPR in Nigeria and other SSA countries may have little to do with a lack of contraceptive knowledge and awareness. Most studies

to date have concentrated on the factors that contribute to low contraception use among women aged 15–49. The relationship between having a high level of knowledge about contraception and using it is not well understood. As a result, this paper aims to fill that gap and push the boundaries of knowledge about contraceptive use in Nigeria and the South-South geopolitical zone even further in assessing the barriers and factors affecting the use of family planning methods among couples. The contraceptive prevalence rate is higher in Nigeria's southern regions on average but lower in the northern regions. This could be due to factors such as conservation, dominant culture, insurgencies, religion and other man-made disasters are all documented reasons. For example, it ranges from 2% in the northern states of Yobe and Sokoto to 29% in Lagos State in Nigeria's south. Low levels of education, a lack of women's autonomy and empowerment, patriarchy, family, and community factors are also issues. In Nigeria, there is evidence of inter-regional disparities in contraceptive use. However, there have been insufficient attempts to illustrate the intra-regional dynamics of contraceptive knowledge and actual use among specific regions. Gender experts agree that males should be encouraged to be supportive partners of women's reproductive health while also meeting their own reproductive health needs, and engaging as agents of change in families and communities. Constructive male engagement in family planning entails a thoughtful, gender-sensitive approach that places gender equality and women's empowerment on equal footing with other desired outcomes. The explosive increase in the nation's population as a result of childbearing, each pregnancy and birth remains a risk-fatal experience for hundreds of millions of women worldwide. Family planning is a means by which individuals or couples space the process of conception, pregnancy and childbirth in intervals, mutually determined by both husband and wife in order to have the desired number of children that they can conveniently cater for their needs. According to Ahmed, Family Planning is the factor that may be considered by a couple in a committed relationship and each individual involved in deciding if and when to have children. Ideally, family planning may involve consideration of the number of children a couple wish to have as well as the age at which they wish to have them. Family Planning are obviously influenced by external factors such as marital situation, career considerations, financial position, any disabilities that may affect their ability to have children and raise them, beside many other considerations. World Health Organization (2017), describe family planning as a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes, and responsible decisions by individuals and couples, in order to promote the health and welfare of the family

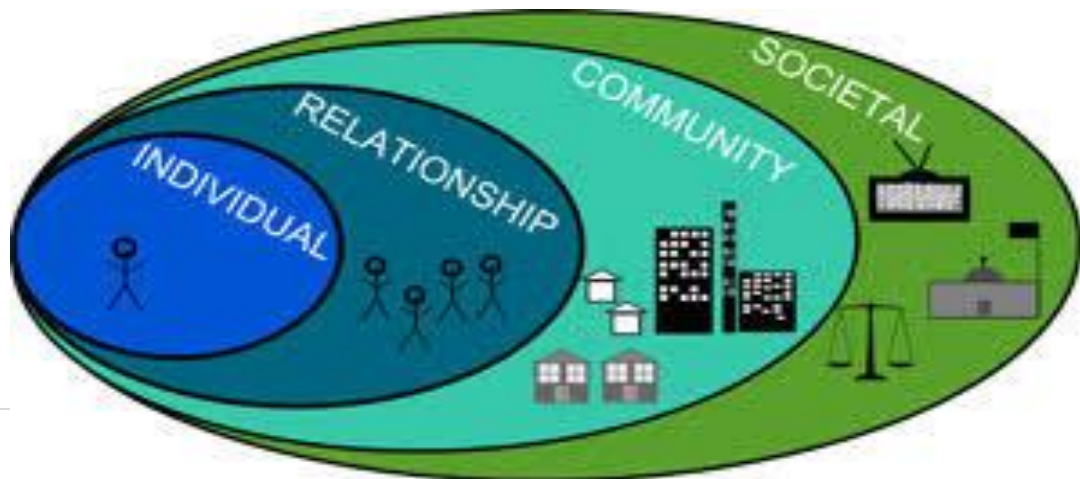
group and thus contribute effectively to the social development of a country. The World Health Organization (WHO) estimates that 287,000 maternal deaths occurred in 2010, sub-Saharan Africa (56%) and southern Asia (29%) accounted for the global burden of maternal deaths. Many countries in sub-Saharan Africa have persistent high rates of unmet need for family planning and relatively low proportions of contraceptive use. Factors affecting service provision include tenuous commodity security and suboptimal service factors. At the individual woman level also, numerous obstacles work against the utilization of family planning service. Studies have shown that barriers to family planning services include risk perception, insufficient knowledge needed to make informed choices, opposition from male partners, and health service limitations.

Constructively engaging men, to be users of Reproductive Health services themselves, shifting gender norms, and improving communication and joint decision making in couples can be challenging and require long-term efforts as a result of low socio-economic factors. This study sought to assess the Knowledge, barriers and factors affecting the use of family planning methods among couples

CONCEPTUAL FRAMEWORKS

The Ecological model of human development has been used by several studies investigating risk and protective factors for couple's sexual needs. This framework places individual at the center of multiple interacting spheres of influence. Closest to the individual are relationships with caregivers and family. More distal are the ways in which individual and family are influenced by community, society, culture and environment. The cumulative and counterbalancing effects of risk and protective factors within and across spheres, depending on their severity and strength, may lead to or prevent individual accessing family planning services.

This ecological theory provides a valuable framework to examine risk and protective factors for individual



Ecological model

- Individual-level factors
 - Intelligence
 - Drug use (risk behaviors)
 - Sexual abuse
- Family-level factors
 - Single-parent homes
 - Poor parenting
 - Low SES
- Extra-familial factors
 - Sexually active friends
 - Committed relationship
 - Low-quality neighborhood
 - Few positive school experiences

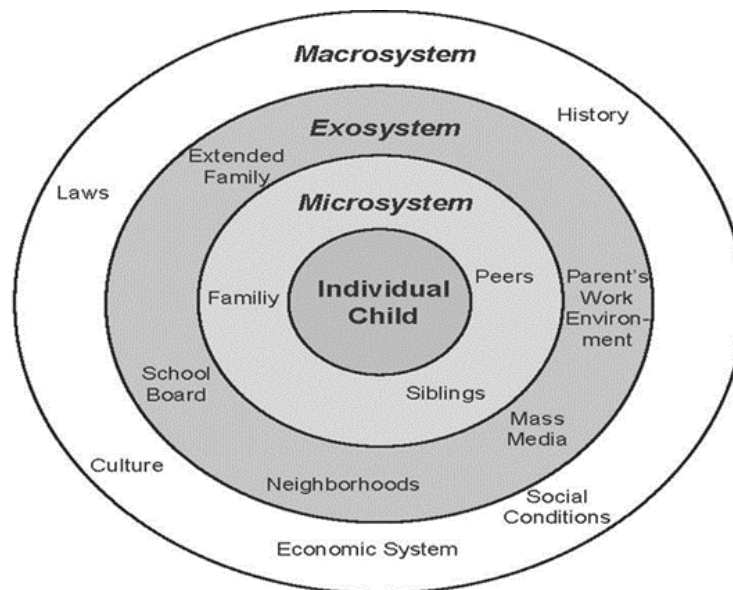


Figure 1: Conceptual framework describing the environmental/societal influences on individuals.

The Health Belief Model (HBM):

The Health Belief Model (HBM) is the commonly used theory in health education and promotion. The underlying concept of the HBM is that health behaviour is determined by personal beliefs or perceptions about a disease and the strategies available to decrease its occurrence. Personal perception is influenced by the whole range of intrapersonal factors affecting health behaviour. The following four perceptions serve as the main constructs of the model:

1. Perceived severity 2. Perceived susceptibility. 3. Perceived benefits. 4. Perceived barriers.

Each of these perceptions, individually or in combination can be used to explain health behavior. Other constructs have been added: thus, the model has been expanded to include cues to action, motivating factors and self-efficacy.

Perceived severity: The construct of perceived severity speaks to an individual's belief about the seriousness or severity of negative health behavior. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties negative health behavior would create or the effects it would have on his or her life in general. The severity in this way could be linked to family planning methods couple need to severely take action to its use

Perceived susceptibility: Personal risk or susceptibility is a powerful perceptions in prompting people to adopt healthier behaviors. The greater the perceived risk, the greater the likelihood of engaging in behaviors that decrease the stated risk. Couple could be prompt to adopt and use any of the family planning methods best suited for them.

Perceived Barrier and Benefits: The last construct to the HBM is the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behavior. Of all the constraints, perceived barriers are the most significant in determining behavior change. In order for a new behavior to be adopted, a person needs to believe that the benefits of the new behavior outweigh to consequences of continuing the old behavior.

Modifying Variables: The four main constructs of perception are modified or influenced by other variables such as culture, education level, past experiences, skills and motivation. These are individual characteristics that influence personal perceptions.

Cues to action: In addition to the four beliefs or perceptions and modifying variables, the HBM suggests that behavior is also influenced by cues to action. These are events, people or things that move people to change their behavior. Examples are media reports and media campaigns, advice from others, reminder postcards from a health care provider or health warnings on product labels. Knowing a person who has gone through a health behavior change and how it has benefited them can also act as a cue to action for others.

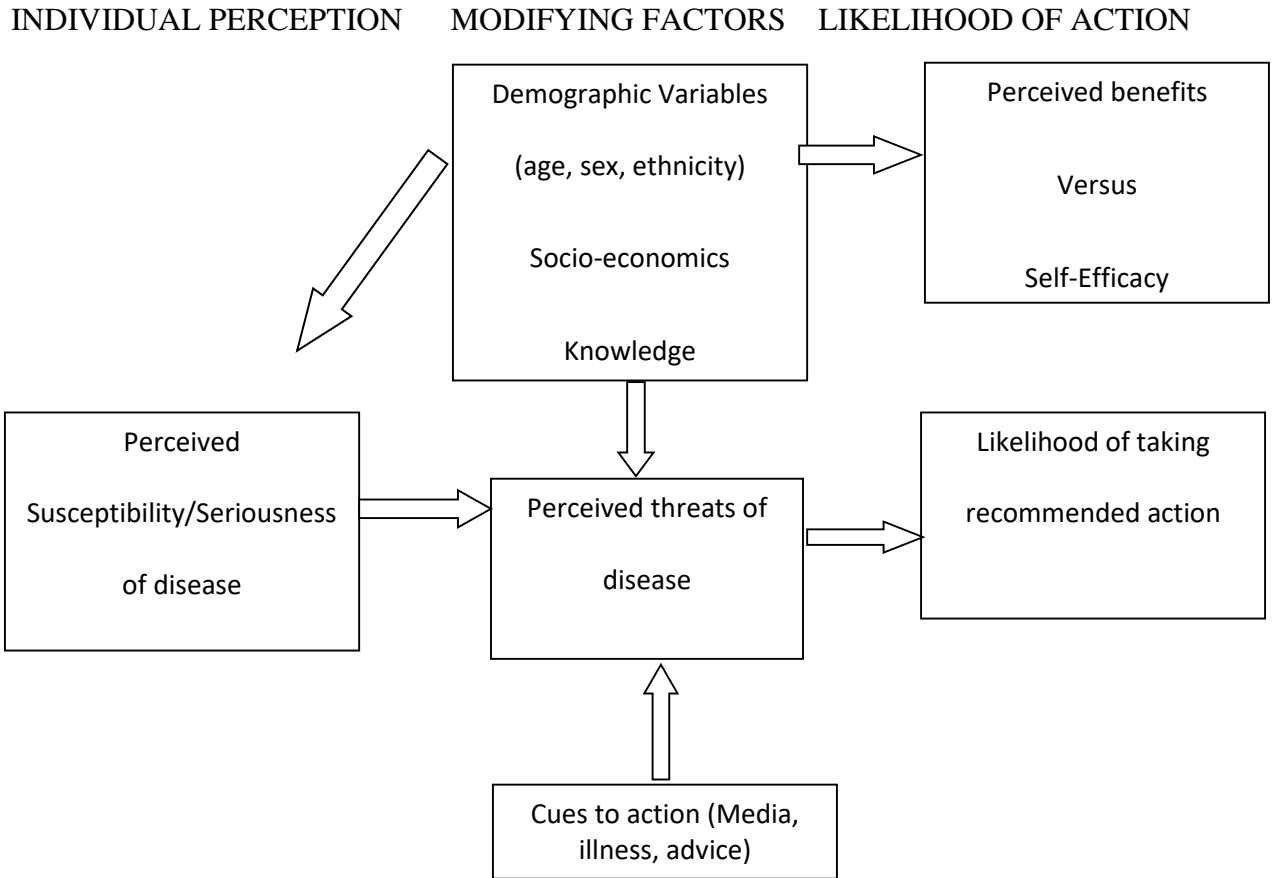


Figure 1: Diagrammatic presentation of The Health Belief Model

Source: The Health Belief Model (based on Health Behaviour and Health Education. Theory, Research and Practice. San Francisco: Wiley & Sons

MATERIALS AND METHODS

Study Area: The police medical services hospital is a renowned para-military hospital situated in the heart of Uyo city, which serves as the capital of Akwa Ibom state in Nigeria's South-South

geo-political zone. Spanning across 23 hectares of land with 20-bed facility stands as a vital pillar in providing top-notch healthcare services to the state's population of approximately 6.0 million, as per the 2006 population census figure. Beyond its role as an health care facility, this remarkable institution diligently caters to the healthcare needs of Uyo's residents, pregnant women and those residing in nearby cities and villages. Furthermore, it serves as a vital referral center for primary and secondary facilities in the state. To cater to their healthcare needs, GOPC and ANC operates from Monday to Friday within the hour of 8am-4pm where they provide services to people ranging from general attendant, vital sign check, consultation, laboratory services, diagnostic and treatment services. Family planning services and Delivery services are manned by trained midwives and doctors including Specialist in Obstetrics and Gynaecology. Apart from English, the primary languages spoken in this region include Ibibio, Annang, Ekid, Oron, and Obolo. These languages reflect the rich cultural diversity of the area and are widely used by the local communities for daily communication and cultural expression.

Study Design: An institution based descriptive cross-sectional study was used to explore knowledge, barriers and factors affecting the use of family planning methods among couples attending antenatal services.

Target Population: The target populations are couples attending antenatal services in Akwa Ibom State.

Sample Size Determination: The Cochran formula was used:

$$n = Z^2PQ/D^2$$

Where,

n = sample size

Z = 95% confidence interval (standard value 1.96)

P = prevalence of family planning use in related study 34%, p=0.34)

Q = 1 - P

D = degree of accuracy at 0.05

$$: n = [(1.96)^2 \times (0.34) \times (0.66)] / (0.05)^2$$

$$n = 345$$

For a known population, the following formula is used; $n = n_0 / 1 + [(n_0 - 1) / N]$

Where,

n_0 = sample size

N = total population

$$n = 345 / 1 + [(345 - 1) / 5000]$$

$$n = 345 / 1 + [344 / 5000]$$

$$n = 345 / 1 + 0.0688$$

$$n = 345 / 1.0688$$

n= 322.8

n ≈ 323.

Sampling Technique: The systematic random sampling method was used to select 323 couples who meet the selection criteria. An average of 400 clients is seen per month in the clinic with an average of 100 per week. Three hundred and seventy-two (323) consenting participants were recruited into the study within 2 months. That was calculated to be $(323/2)$ 161 per month 40 per week and approximately 10 per day. The first participant was selected using a simple random sampling method by balloting. Systematically, every 10th participants were recruited daily from the pool. To avoid double enrollment, the client's hospital blue card was tagged with a colored sticker after enrollment, and a serial number was given for easy identification. The selection was done until the required minimum sample size was achieved.

Method of data collection: An interviewer administered questionnaire was used to obtain data from the respondents. English language was the medium of communication. Respondents with no formal education were assisted with use of local dialect by research assistants. The data collected from the respondents include socio-demographic characteristics, awareness/knowledge of family planning methods and risk factors/ barrier in using family planning methods. With the permission of the Head of Department GOPC and matron in-charge of ANC, the selected participants were encouraged to respond to the questionnaire accurately. To ensure confidentiality and an atmosphere devoid of external influence, the matron, nurses and auxiliary staff were not present to interfere at participant side while the participants completed the questionnaires. Also, the participants were spaced so that they could not interact with one another while responding to the questionnaire. The questionnaires were interviewer- administered. The research team was made up of the researcher and 2 research assistants drawn from the Hospital (2 doctors with MBBS, Two weeks prior to the commencement of data collections, two research assistants were trained for one day in 2 sessions each lasted for about 3 hours on how the questionnaires was administered, filled and retrieved. The training captured an overview of family planning methods, aim/objectives of the study, the sensitivity of the topic and the style of interview. Using a sample of the questionnaire, a detailed explanation of each question was made. An understanding of the methodology, co-ordination of the project, logistics and standardization of the process was also emphasized during the training.

Pretesting: The pre-test was done to assess the applicability of the questionnaire internally and externally. All the clients used for the pretesting of the questionnaire instrument gave valid and reliable responses. This has confirmed the clarity and applicability of the questionnaires. Questions were interpreted with the same meaning as intended. The questionnaires were administered by the researcher and assistants.

Inclusion criteria: All adult clients/couples attending antenatal services

Exclusion criteria: Severely ill patients, unconsented clients

Instrument for data collection: Interviewer administered questionnaire was divided into these sections. A. Social demographic characteristics of respondents B. Knowledge and the practice of family planning methods among respondents. C. Barriers and factors affecting the use of family planning questionnaire

Data analysis: The data entry and analysis was carried out using Statistical Package for Social Sciences (IBM SPSS) version 27 software. The results obtained from the socio-demographic characteristics of the respondents were summarized using frequency tables. All categorical variables were summarized using percentages and proportions while the continuous variables were summarized using mean and standard deviations or median and interquartile range for skewed data.

Ethical considerations: Ethical approval for this study was obtained from the Institutional Health, Research and Ethical Committee, and the Chief Medical Officer in charge obtained permission to carry out the study. The researcher sought and obtained permission from the Head of Department GOPC/ANC and the matron in charge of the GOPC/ANC. Written consent was obtained from participants. The interviewer-administered questionnaire was completed by the participants after an adequate explanation of the purpose of the study and the contents of the questionnaire. Questions raised concerning the questionnaire were addressed. Privacy was ensured with spacing of the participants. Confidentiality was assured as the participants were informed not to mention their names on the questionnaire and all the personal identifying information such as phone numbers, addresses and names of respondents were not captured on the questionnaire nor electronically. Serial numbers and not names of participants were used to ensure confidentiality. The respondents were assured that their responses would be kept confidential and the questionnaires would be kept in a safe place and would only be accessible to members of the research team.

Limitations of the study: One-site setting: The study is limited by the use of one study setting which could affect the generalizability of the study, financial constraint.

RESULTS:

A total of 323 respondents were recruited and all respondents completed and returned the questionnaires given a response rate of 100%.

Table 1: Showing the demographic characteristics of the respondents

Variables	Categories	Frequency	Percent
Age in years	15-25years	56	11.1
	26-35years	141	34.4
	36-45years	126	39.0
Ethnicity	Oron	69	21.4
	Annang	123	38.1
	Ibibio	131	40.6
Educational level	No formal education	38	11.8
	Primary	56	17.3
	Secondary	143	44.3
	Tertiary	86	26.6
Marital status	Single	57	17.6
	Married	207	64.1
	Divorced	40	12.4
	Separated	19	5.9
Religion	Christianity	310	9.8
	Islam	13	2.0
Employment status	Unemployed	38	11.8
	Self-employed	186	57.6
	Employed	99	30.7
Number of children	No child	37	11.5
	1child	76	23.5
	2children	41	12.7
	3children	54	16.7
	4children	66	20.4
	More than 4children	49	15.2
Desired number of children	1child	19	5.9
	2children	173	53.6
	3children	85	26.3
	4children	29	9.0
	More than 4children	17	5.3
	Total	323	100.0

Table 1 above shows majority 126(39%) of the respondents are within 34-41years, 111(34.4%) are 26-33years, 50 (15.5%) are 42years and above and 36(11.1%) are within 18-25years. Majority

131(40.6%) are Ibibio. The educational level shows majority 143(44.3%) have secondary level education, 86(26.6%) have tertiary level of education.

Table 2: showing the level of knowledge on family planning methods among respondents

Variables	Categories	Frequenc y	Percen t
Do you know any family planning methods specifically for men/women	Yes	311	96.3
	No	12	3.7
If yes, what methods do you know	Barrier method (male/female condoms)	258	80.0
	Surgical method (Tubal ligation/vasectomy)	67	20.6
	Male/Female traditional method (periodic abstinence and withdrawal)	132	40.8
	Oral method	19	5.9
What method of contraceptive for a man/woman who has reached his desired number of children	Condoms	108	33.4
	Periodic abstinence and withdrawal	86	26.6
	Vasectomy/Tubal ligation	34	10.5
	Pills	95	29.4
Do you know about family planning services available in environment	Yes	258	78.9
	No	65	21.1
Have you or your partner used any family planning methods	Yes	181	56.0
	No	142	44.0
	Total	323	100.0

Table 2 majority 311(96.3%) know family planning methods specifically for men and women. The knowledge distribution shows 258(80%) knows barrier method (male/female condoms), 67(20.6%) knows surgical method (vasectomy/ligation), 132(40.8%) knows male/female traditional method (periodic abstinence and withdrawal), 19(5.9%) knows oral method.

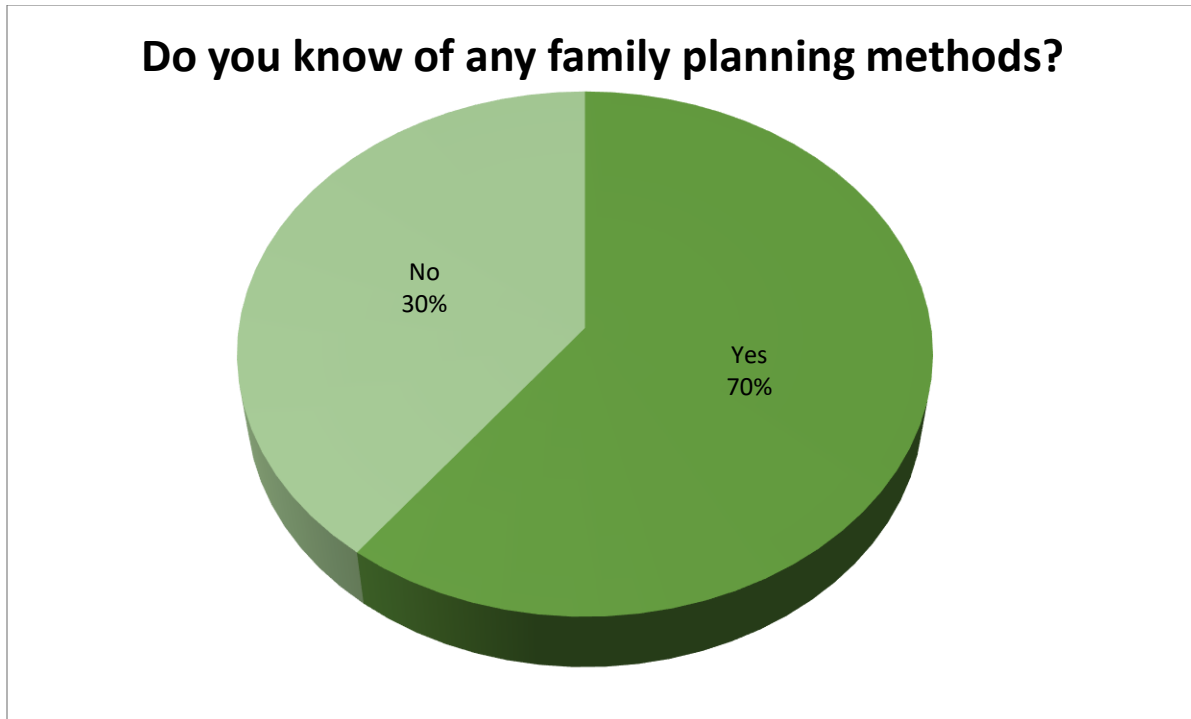


Figure 1: pie-chart showing the level of knowledge of respondents on family planning methods

It was observed that majority of the respondents 70% know about family planning methods

Table 3: showing the level practice of family planning methods

Variables	Categories	Frequency	Percent
Have you or your partner used any family planning methods before	Yes	181	56.0
	No	142	44.0
Do you use contraceptives to stop unplanned pregnancy	Yes	147	45.5
	No	176	54.5
Do you use contraceptives anytime you don't intend to get pregnant	Yes	147	45.5
	No	176	54.5
Does your methods of family planning changes from time to time	Yes	145	44.9
	No	178	55.1
	Total	323	100.0

Table 3 shows 181(56%) of the respondents have used family planning methods before, 147(45.5%) use contraceptives to stop unplanned pregnancy, 145(44.9%) changes their family planning method from time to time.

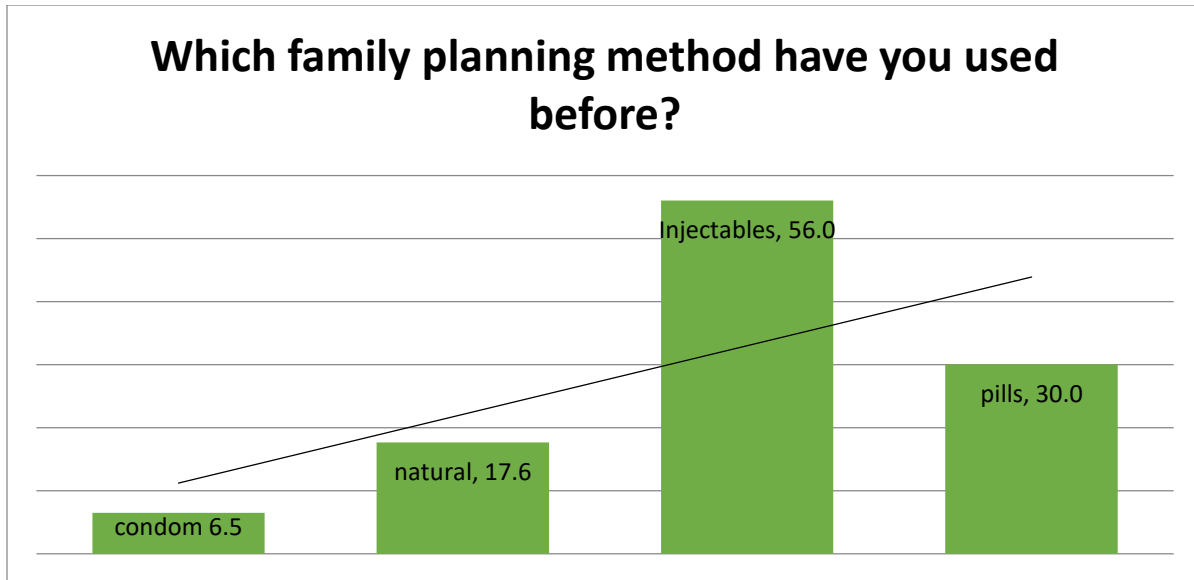


Figure 2: showing the practice of family planning methods. Majority 56% use injectable, 30% use pills, 17.6% use natural family planning method while 6.5% use condoms.

Table 4 showing the factors associated with Knowledge of family planning methods

Variables	Categories	Frequency	Percent
Are there any challenges to accessing family planning services	Yes	213	65.9
	No	110	34.1
My religion prohibits it	Yes	60	18.6
	No	263	81.4
Does distance affect your ability to go for family planning services	Yes	121	37.5
	No	202	62.5
Is it convenient and safe to access family planning services	Yes	186	57.6
	No	137	42.4
Do you have to pay for family planning service	Yes	227	70.3
	No	96	29.7
I use natural family planning method	Yes	97	30.0
	No	226	70.0
I did not use it because of my previous experience of family planning?	Yes	164	50.8
	No	159	49.2
My culture and believe disallows it	Yes	96	29.7
	No	227	70.3
	Total	323	100.0

Table 4 shows factors associated to the practice of family planning include cost (70.3%), challenges in accessing the services (65.9%), previous experiences (50.8%), distance (37.5%), culture (29.7%) and religion (18.6%).

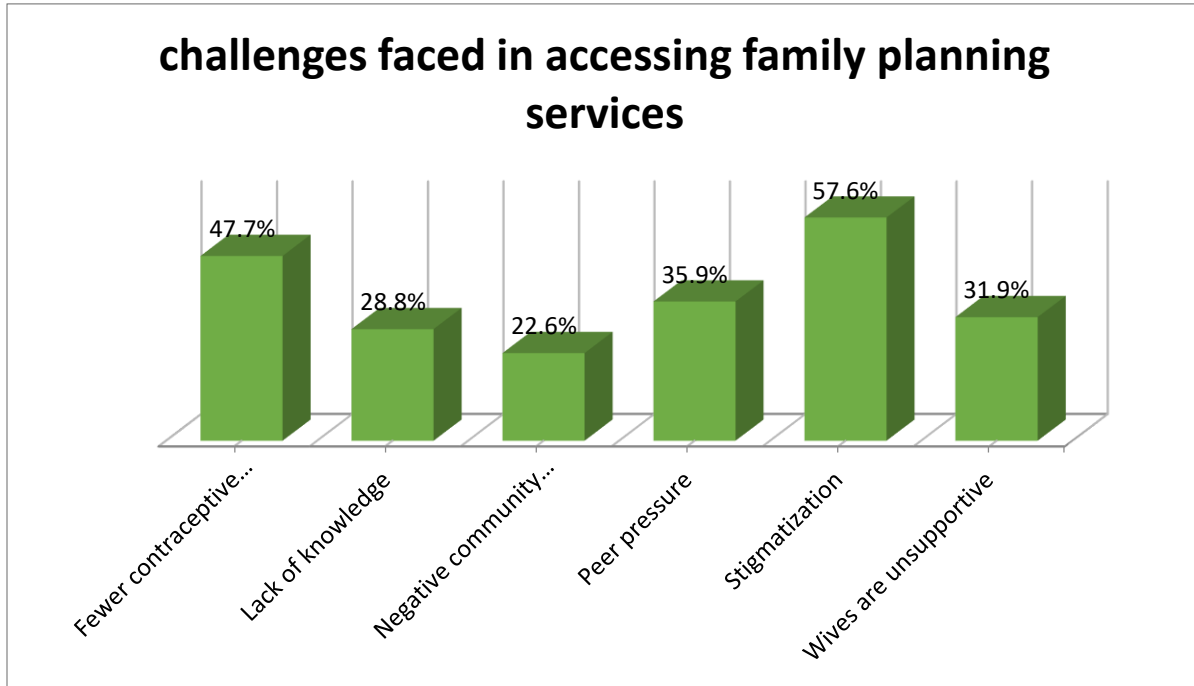


Figure 4: showing the factors associated with the Knowledge and practice of family planning methods

The challenges faced in accessing family planning services for males include; stigmatization (57.6%), fewer contraceptive choices for men (47.7%). Other challenges are peer pressure (35.9%), unsupportive husbands (31.9%), lack of knowledge about the methods to use (28.8%) and negative community perception and believes (22.6%).

DISCUSSION

Level of knowledge concerning family planning methods

The present study quantified knowledge and use of contraception among couples attending antenatal services in Akwa Ibom state. About 96.3% of the men/ women know about family planning methods. This is similar but relatively lower than the 98% reported in the findings of a study conducted. This is so while women commonly access healthcare facilities for antenatal care and childhood immunization visits, men are far less likely to have healthcare needs that bring them

to hospitals and clinics where they might encounter accurate family planning information. It is therefore essential to make awareness and reach men with information about family planning methods for them. Ijeoma *et al.*, established that the level of knowledge of family planning among the married men in Evuma Community, Afikpo, Ebonyi State, Nigeria was high (96.4%). The major source of information was through sensitization from health workers at the health centres as well as from friends/relations. Adams also revealed that a high level of awareness of family planning methods is made possible mainly through hospital campaigns followed by exchange of information between friends/relations. Men were most familiar with barrier method (male condoms), but many also named male traditional method (periodic abstinence and withdrawal), surgical method (vasectomy) and oral method. Increasing knowledge and acceptability of these methods among men could be one avenue for increasing use of these very effective methods. Importantly, such efforts will only be successful if there are also parallel efforts to address lack of availability of these methods for men.

Level of practice of family planning methods

The study also revealed that the practice of family planning among clients attending antenatal services with couples was average (56.0%). This finding indicates a gap between the level of knowledge and the practice of family planning among them. This view is similar with a study which revealed that majority of the respondents know about some modern contraceptive methods, but the overall contraceptive use was very low. However, it disagrees with study that revealed that majority of the respondents had good knowledge regarding the meaning, types and uses of contraceptives which resulted in high attitude and good practice pattern. These findings point to the fact that there is a very wide gap between the knowledge of family planning in this setting and their practice of family planning. This view was supported by who posited that, in many other African countries, there exists a very wide gap between contraceptive knowledge and practice. They posited that current contraceptive use in Africa stood at 29 % while knowledge was well over 80 % This view is also consistent with the findings who revealed that it was not every couple who approved family planning actually practiced it for reasons such as the fear of failure, cultural and religious prohibition as well as disagreements between couple.

Family planning programs need to target men at all levels of health promotion and education with their partners to reduce misconceptions about FP methods to increase acceptance. Men's

participation is crucial to help reduce misconception about side effects of contraceptive methods. Therefore, FP family programs need to target men at all levels of the service while keeping in mind women too. Their involvement will also lead to women's empowerment to increase effective contraceptive use and continuation to improve better health outcomes in reproductive health. User experiences indicate that text messages provide a novel way to raise awareness, promote behavior change and address myths and socio-cultural norms

Factors associated with the knowledge and practice of males in family planning methods

The challenges faced in accessing family planning services for males and females in the current study include; stigmatization (57.6%), fewer contraceptive choices for men (47.7%), peer pressure (35.9%), unsupportive wives (31.9%), lack of knowledge (28.8%), culture (29.7%) and religion (18.6%), cost (70.3%) and negative community perception (22.6%). Similarly, non-approval of family planning methods by men in was attributed to perceived risks, side effects, and socio-cultural norms. Focus group discussions with men and women in rural Uganda have come out with similar findings. Contraceptive knowledge and use are shaped by the socio-cultural environment such as personal attitudes and feelings about contraception.

Evidence shows that some men and fewer number of females oppose contraceptive use for reasons of tradition and religion which require men to maintain the honor and position of their extended family, village, religious group and social organization. Studies have shown with similar findings in settings in rural northern Ghana. The complex web of social and cultural factors impedes spousal communication regarding reproductive health issues and that discourages them to take their wives to health clinics to discuss FP issues.

Conclusion

This study provides information on the types of family planning information couples can key, the knowledge, barriers and factors affecting the family planning use. Its therefore posited that reproductive health program designers need to incorporate these findings into reproductive health programs to help address barriers to improve health outcomes among males.

Recommendations

i. Attention is needed at community and governmental level to identify strategies to promote gender equity, shared decision making, shared responsibility, positive participation of men, empowering women, and to increase effectiveness of male participation in family planning use.

Male focused programs, intensive education for men and religious leaders should also be considered.

ii. Governmental and non-governmental organizations, donors and relevant stakeholders should ensure availability, accessibility and sustained advocacy for the use of FP for couples.

iii. Service delivering centers need to be properly equipped with materials to motivate couples to use the services.

REFERENCES

1. Adekanle, D. A., Isawumi, A. I., & Adekeye, O. A. (2017). Knowledge and use of family planning methods among female undergraduates in a Nigerian university. *Journal of Family Planning and Reproductive Health Care*, 43(3), 236-242. doi: 10.1136/jfprhc-2016-101634
2. Bongaarts, J. (2017). Trends in contraceptive prevalence and use in developing countries. *Studies in Family Planning*, 48(2), 147-164. doi: 10.1111/sifp.12024
3. Ezeh, O. K., Onwuzurike, B. K., & Onyeneho, N. G. (2018). Family planning and reproductive health among Nigerian university students: A review. *Journal of Family and Reproductive Health*, 12(2), 53-63.
4. National Population Commission. (2017). Nigeria demographic and health survey 2018. Abuja, Nigeria: National Population Commission.
5. Sedgh, G., Finer, L. B., Bankole, A., Eilers, M. A., & Singh, S. (2016). Adolescent pregnancy, birth, and abortion rates across countries: Levels and recent trends. *Journal of Adolescent Health*, 58(5), 557-566. doi: 10.1016/j.jadohealth.2015.09.027
6. Udoh, E. E., Archibong, V. I., & Ekong, E. E. (2019). Family planning and reproductive health services in Akwa Ibom State, Nigeria: A review. *Journal of Family and Reproductive Health*, 13(1), 1-9.
7. Adelekan, A., Omoregie, P., & Edoni, E. Knowledge and practice of males in Family Planning: Challenges and Way Forward. *Int'l J of Population Research*, 2017
8. Adongo, P. B., Tabong, P. T., Azongo, T. B., Phillips, J. F., Sheff, M. C., Stone, A. E., & Tapsoba, P. The same contraceptive method but different stories : A comparative qualitative

study of the misconceptions associated with contraceptive use in southern and northern Nigeria. ResearchGate 2018.

9. Ahmed-Adams Zainab B. Knowledge, attitude and practice of natural family planning among couples in Kaduna metropolis. A thesis submitted to the school of postgraduate studies, Ahmadu Bello University, Zaria 2020.

10. Alsaedi, J., Alakel, S., Alalmaei, A., Al-Mutairi, M., Almutair, S. (2018). Assessment of Knowledge, Attitude and Practice towards Family Planning in Saudi Arabia,. *The Egyptian Jour of Hospital Med*, 2017,70(2), 345-348.

11. Eliason, S., Baiden, F., Yankey, B.A. *et al.* Determinants of unintended pregnancies in rural Ghana. *BMC Pregnancy Childbirth* 2018,14, 261.

12. Emmanuel Okwudili Oranu, Ijeoma Chioma Oppah *Journal of Biosciences and Medicines* Vol.8 No.8, August 18, 2020

13. Ezeh AC Izugbara CO. Women and high fertility in Islamic northern Nigeria. *Stud Family Plan* 2018; 41:193-20